

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 10 1960

-60-037087

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2776 STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cool Valley</u>		Length of stay in 1b <u>3 Days</u>		c. CITY OR TOWN <u>Ferguson</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Hilltop House</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>41 No. Dade</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jacqueline</u> Middle <u>A.</u> Last <u>Suchy</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>19</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-8-93</u>	9. AGE (last birthday) <u>67</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (City and state or country) <u>Lincoln Nebr.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Andrew Weiberg</u>		13b. MOTHER'S MAIDEN NAME <u>Kjerstie Larson</u>		14. NAME OF HUSBAND OR WIFE <u>Robert A Suchy</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>492-01-1154</u>		17. INFORMANT <u>Edwin Crowe</u> Address <u>8615 Martony Berkeley</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonic hypostatic</u> DUE TO (b) <u>Cerebral metastases</u> DUE TO (c) <u>Carcinoma left breast</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>None</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>2 wks</u> <u>1 year</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <u>January 11, 60</u> to <u>Sept. 19, 60</u> and last saw her alive on <u>9/19/60</u> Death occurred at <u>7:30 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Joseph F. Kelly</u> (Degree or title) <u>MD</u>		22b. ADDRESS <u>111 Church</u> <u>Ferguson, Mo.</u>		22c. DATE SIGNED <u>9/19/60</u> (State)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9-21-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>		23d. LOCATION (City, town, or county) <u>Normandy</u> (State) <u>Mo.</u>	
24. FUNERAL DIRECTOR <u>White-Mullen Mortuary</u>		ADDRESS <u>Ferguson Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>9-19-60</u>		26. REGISTRAR'S SIGNATURE <u>John C. Murphy, Md.</u>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to
with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.